

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0021493</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>APOSTOLIC CHRISTIAN HOME</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>1102 W. RANDOLPH ST.</u> <u>ROANOKE</u> <u>61561</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>WOODFORD</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>RICHARD D. ISAIA</u> (Title) <u>ADMINISTRATOR</u>	
Telephone Number: <u>(309) 923-2071</u> Fax # <u>(309) 923-7919</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()	
IDPA ID Number: <u>37-0990253001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>5/5/1975</u>			
Type of Ownership:			
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT			
<input checked="" type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
IRS Exemption Code <u>501 (C) (3)</u>			
<input type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
GOVERNMENTAL			
<input type="checkbox"/> State			
<input type="checkbox"/> County			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>RICHARD D. ISAIA</u> Telephone Number: <u>(309) 923-2071</u>			

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME# 0021493 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>60</u>	Skilled (SNF)	<u>60</u>	<u>21,960</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>60</u>	TOTALS	<u>60</u>	<u>21,960</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,173</u>	<u>11,135</u>	<u>686</u>	<u>20,994</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,173</u>	<u>11,135</u>	<u>686</u>	<u>20,994</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 95.60%

D. How many bed-hold days during this year were paid by Public Aid?

23 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)OUTPATIENT PART B THERAPYF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 05/05/75

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 6 and days of care provided 686Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

APOSTOLIC CHRISTIAN HOME

0021493

Report Period Beginning:

1/1/00

Ending:

12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	168,815	13,203	10,435	192,453		192,453		192,453		1
2	Food Purchase		103,868		103,868		103,868	(4,294)	99,574		2
3	Housekeeping	108,918	1,805	2,139	112,862		112,862		112,862		3
4	Laundry	47,347	6,471	2,041	55,859		55,859		55,859		4
5	Heat and Other Utilities			51,898	51,898		51,898		51,898		5
6	Maintenance	38,294	20,319	25,602	84,215		84,215		84,215		6
7	Other (specify):*		3,711	75,660	79,371		79,371	(79,371)			7
8	TOTAL General Services	363,374	149,377	167,775	680,526		680,526	(83,665)	596,861		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,021,540	105,455	37,940	1,164,935	(16,010)	1,148,925		1,148,925		10
10a	Therapy	74,800	1,291	4,961	81,052		81,052		81,052		10a
11	Activities	66,056	6,231	2,540	74,827		74,827		74,827		11
12	Social Services	26,059	3,468	1,065	30,592		30,592		30,592		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,188,455	116,445	46,506	1,351,406	(16,010)	1,335,396		1,335,396		16
	C. General Administration										
17	Administrative	55,777			55,777		55,777		55,777		17
18	Directors Fees										18
19	Professional Services			12,820	12,820		12,820		12,820		19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	73,840	10,457	36,787	121,084		121,084		121,084		21
22	Employee Benefits & Payroll Taxes			237,366	237,366		237,366		237,366		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			12,383	12,383		12,383		12,383		26
27	Other (specify):*										27
28	TOTAL General Administration	129,617	10,457	299,356	439,430		439,430		439,430		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,681,446	276,279	513,637	2,471,362	(16,010)	2,455,352	(83,665)	2,371,687		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number

APOSTOLIC CHRISTIAN HOME

#0021493

Report Period Beginning:

1/1/00

Ending:

12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			190,448	190,448		190,448	(38,611)	151,837			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,235	53,235		53,235	(53,235)				32
33	Real Estate Taxes			14,336	14,336		14,336	(14,336)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			258,019	258,019		258,019	(106,182)	151,837			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			3,951	3,951		3,951		3,951			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,940	32,940		32,940		32,940			42
43	Other (specify):* MED. PHARMACY					16,010	16,010		16,010			43
44	TOTAL Special Cost Centers			36,891	36,891	16,010	52,901		52,901			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,681,446	276,279	808,547	2,766,272		2,766,272	(189,847)	2,576,425			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME

0021493

Report Period Beginning: 1/1/00

Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,294)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(53,235)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(132,318)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (189,847)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (189,847)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs	X		16,010	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 16,010		47

NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1 NON-ALLOWABLE REAL ESTATE TAXES	\$ (497)	33	1
2 COUNTRY VIEW EXPENSES	(69,230)	7	2
3 COUNTRY VIEW DEPR.	(28,093)	30	3
4 DUPLEX EXPENSES	(16,141)	7	4
5 DUPLEX DEPR.	(16,558)	30	5
6 DUPLEX REAL ESTATE TAXES	(13,839)	33	6
7			7
8			8
9			9
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81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90 Total	(132,318)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME

0021493

Report Period Beginning:

1/1/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,294)	0	0	0	0	0	0	0	0	0	0	(4,294)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	(79,371)	0	0	0	0	0	0	0	0	0	0	(79,371)	7
8	TOTAL General Services	(83,665)	0	0	0	0	0	0	0	0	0	0	(83,665)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(83,665)	0	0	0	0	0	0	0	0	0	0	(83,665)	29

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NONE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2	NONE										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME# 0021493

Report Period Beginning:

1/1/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10	COMMERCE BANK		X	COUNTRY VIEW BLDG.LOA	\$7,800.00	03/28/00	875,000	846,285	2/10/15	6.8500	53,235	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related					\$7,800.00		\$ 875,000	\$ 846,285			\$ 53,235	14
15	TOTALS (line 9+line14)							\$ 875,000	\$ 846,285			\$ 53,235	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **APOSTOLIC CHRISTIAN HOME**# **0021493**

Report Period Beginning:

1/1/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	2
3. Under or (over) accrual (line 2 minus line 1).	\$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

	FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

ALL REAL ESTATE TAXES ARE NON-ALLOWABLE AND ARE ADJUSTED OUT OF SCHEDULE V

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

A. Square Feet:
33,601

B. General Construction Type:

Exterior
BRICK

Frame
BLOCK & WOOD

Number of Stories
1

C. Does the Operating Entity?

☒ (a) Own the Facility
☐ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment
☐ (b) Rent equipment from a Related Organization.
☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

APOSTOLIC CHRISTIAN HOME OF ROANOKE DUPLEXES (INDEPENDENT LIVING UNITS) - 10 UNITS

APOSTOLIC CHRISTIAN HOME OF ROANOKE COUNTRY VIEW APARTMENTS (INDEPENDENT LIVING UNITS) - 14 UNITS

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	BLDG & GROUNDS	100,000	1975	\$ 35,875	1
2					2
3	TOTALS	100,000		\$ 35,875	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1975	1958	\$ 202,000	\$	30	\$		\$	4
5			1976	1976	22,708	5,638	30	5,638		202,156	5
6			1991	1991	671,286	22,376	30	22,376		203,249	6
7			1992	1992	129,607	4,469	30	4,469		37,986	7
8											8
	Improvement Type**										
9	LAND & BLDG. IMPROVEMENTS			1976	105,004						9
10				1977	6,591						10
11				1978	10,960						11
12				1979	9,124						12
13				1980	8,166						13
14				1981	6,506						14
15				1982	18,087						15
16				1983	36,023						16
17				1984	12,947						17
18				1985	13,333	18,376	VARIOUS	18,376		530,752	18
19				1986	8,595						19
20				1987	87,248						20
21				1988	43,526						21
22				1989	64,604						22
23				1990	11,217						23
24				1991	3,700						24
25				1992	5,410						25
26				1993	36,135						26
27				1994	14,661						27
28				1995	30,372						28
29	SOILED UTILITY REMODELING			1996	680	97	7	97		340	29
30	FIXED TV MONITORING SYSTEM			1996	278	40	7	40		139	30
31	REMODEL 14 EAST			1996	2,781	397	7	397		1,390	31
32	NEW SIDEWALK			1996	1,375	196	7	196		687	32
33	ROOM REMODELING (9,21,17)			1997	1,641	1,641	7	1,641		5,743	33
34	ROOM REMODELING (11,8,10,19,5,6)			1997	2,436	2,436	7	2,436		8,525	34
35											35
36	TOTAL (lines 4 thru 35)				\$ 1,567,001	\$ 55,666		\$ 55,666	\$	\$ 990,967	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME

0021493

Report Period Beginning:

1/1/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		FIRE ALARM SYSTEM COSTS		1998	12,671	1,810	7	1,810		4,525	9
10		ROOM REMODELING (3,12,14)		1998	13,953	1,993	7	1,993		4,983	10
11		GAS LINE WORK		1998	1,033	147	7	147		368	11
12		PARKING LOT		1998	19,397	2,771	7	2,771		6,927	12
13		COURTYARD		1998	15,971	2,282	7	2,282		5,704	13
14		FIRE ALARM SYSTEM COSTS		1999	87,698	12,528	7	12,528		18,792	14
15		CALL LIGHT SYSTEM COSTS		1999	40,500	5,785	7	5,785		8,678	15
16		EAST ROOM REMODELING		1999	23,345	3,335	7	3,335		5,002	16
17		PT RESTROOM REMODEL		1999	605	87	7	87		130	17
18		MULTIPURPOSE ROOM REMODEL		1999	1,438	205	7	205		308	18
19		SPRINKLER SYSTEM ADDITIONS		1999	3,166	452	7	452		678	19
20		STROM SEWER WORK		1999	2,396	342	7	342		513	20
21		DOOR ALARM SYSTEM		1999	2,075	296	7	296		444	21
22		WEST STATION ARCHITECT FEES		1999	4,742	677	7	677		1,016	22
23		EAST SIDE STATION REMODEL		2000	43,536	3,109	7	3,109		3,109	23
24		WEST SIDE STATION		2000	4,637	331	7	331		331	24
25		CALL LIGHT SYSTEM COSTS		2000	11,500	821	7	821		821	25
26		DOOR ALARM SYSTEM REMODEL		2000	2,093	149	7	149		149	26
27		RESIDENT ROOM REMODEL		2000	7,066	505	7	505		505	27
28		LANDSCAPING		2000	3,152	315	7	315		315	28
29		WATER MAIN EXTENSION		2000	1,675	167	7	167		167	29
30											30
31											31
32											32
33											33
34											34
35											35
36		TOTAL (lines 4 thru 35)			\$ 302,649	\$ 38,107		\$ 38,107	\$	\$ 63,465	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 243,765	\$ 45,843	\$ 45,843	\$		\$ 210,364	37
38	Current Year Purchases	23,732	2,373	2,373			2,373	38
39	Fully Depreciated Assets	361,933					361,933	39
40								40
41	TOTALS	\$ 629,430	\$ 48,216	\$ 48,216	\$		\$ 574,670	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	RESIDENT TRIPS	FORD 1999	1999	\$ 49,239	\$ 9,848	\$ 9,848	\$	5	\$ 14,772	42
43										43
44										44
45										45
46	TOTALS			\$ 49,239	\$ 9,848	\$ 9,848	\$		\$ 14,772	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 2,584,194	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 151,837	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 151,837	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,643,874	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	GROUPS -LAND	\$ 28,751	\$	\$	52
53	DUPLEXES	341,312	9,780	27,972	53
54	COUNTRY VIEW APARTMENTS	1,092,486	23,026	34,458	54
55	DUPLEX FURN & FIX	2,100	739	949	55
56	COUNTRY VIEW FURN & FIX	32,131	5,066	6,921	56
57	TOTALS	\$ 1,496,780	\$ 38,611	\$ 70,300	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

1. Name of Party Holding Lease: **NONE**

If NO, see instructions.

14. _____ /2003 \$ _____

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$		17
18					18
19					19
20					20
21	TOTAL		\$		21

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input checked="" type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input checked="" type="checkbox"/> HOURS PER AIDE _____
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	NONE	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):								13	
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 204,039	\$	1
2	Cash-Patient Deposits	802		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	136,384		3
4	Supply Inventory (priced at)	20,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	18,410		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 379,635	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	64,627		13
14	Buildings, at Historical Cost	3,327,907		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	713,990		16
17	Accumulated Depreciation (book methods)	(1,716,641)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,389,883	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,769,518	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 38,117	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	802		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	47,835		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,145		31
32	Accrued Real Estate Taxes(Sch.IX-B)	15,216		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 119,115	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	846,285		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUPLEX EQUITY	446,780		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,293,065	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,412,180	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,357,338	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,769,518	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,522,327	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,522,327	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(304,721)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	139,732	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (164,989)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,357,338	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,653,018	1
2	Discounts and Allowances for all Levels	(382,618)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,270,400	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,294	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,294	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8,253	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,253	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	COUNTRY VIEW INCOME	131,619	28
28a	DUPLEX INCOME	46,985	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 178,604	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,461,551	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	680,526	31
32	Health Care	1,351,406	32
33	General Administration	439,430	33
B. Capital Expense			
34	Ownership	258,019	34
C. Ancillary Expense			
35	Special Cost Centers	3,951	35
36	Provider Participation Fee	32,940	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,766,272	40
41	Income before Income Taxes (line 30 minus line 40)**	(304,721)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (304,721)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME# 0021493Report Period Beginning: 1/1/00Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,970	2,080	\$ 43,825	\$ 21.07	1
2	Assistant Director of Nursing	1,508	1,693	29,534	17.44	2
3	Registered Nurses	18,704	15,075	278,239	18.46	3
4	Licensed Practical Nurses	3,522	4,233	78,319	18.50	4
5	Nurse Aides & Orderlies	54,582	58,739	591,623	10.07	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,227	5,572	74,800	13.42	8
9	Activity Director	2,099	2,324	24,879	10.71	9
10	Activity Assistants	5,307	5,514	41,177	7.47	10
11	Social Service Workers	1,770	1,896	26,059	13.74	11
12	Dietician					12
13	Food Service Supervisor	1,891	2,160	24,766	11.47	13
14	Head Cook	4,953	6,729	58,614	8.71	14
15	Cook Helpers/Assistants	11,478	12,143	85,435	7.04	15
16	Dishwashers					16
17	Maintenance Workers	2,778	3,002	38,294	12.76	17
18	Housekeepers	11,383	12,349	86,598	7.01	18
19	Laundry	5,244	5,748	47,347	8.24	19
20	Administrator	1,966	2,000	55,777	27.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,901	7,489	73,840	9.86	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>HSKG. SUPER.</u>	1,907	2,160	22,320	10.33	33
34	TOTAL (lines 1 - 33)	143,190	150,906	\$ 1,681,446 *	\$ 11.14	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	44	761	10-C	52
53	TOTAL (lines 50 - 52)	44	\$ 761		53

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
RICHARD D. ISAIA	ADMINISTRATOR	0	\$ 55,777	Workers' Compensation Insurance		\$ 36,065	IDPH License Fee	\$
				Unemployment Compensation Insurance		5,312	Advertising: Employee Recruitment	
				FICA Taxes		125,036	Health Care Worker Background Check	
				Employee Health Insurance		70,953	(Indicate # of checks performed _____)	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
TOTAL (agree to Schedule V, line 17, col. 1)							EXPENSES FOR BACKGROUND CHECKS	0
(List each licensed administrator separately.)			\$ 55,777				ARE IN LINE 10 COL. C, NURSING MISC.	
B. Administrative - Other								
Description			Amount				Less: Public Relations Expense	()
			\$ 0				Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 237,366		TOTAL (agree to Sch. V, line 20, col. 8)	\$
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Amount	
Vendor/Payee	Type		Amount		Line #	Amount	Description	Amount
BOB REIN CPA	ACCTG.		\$ 2,760			\$ 0	Out-of-State Travel	\$ 0
	SERVICES							
HEINOLD-BANWART	ACCTG.		700					
	SERVICES						In-State Travel	
HEALTH OUTCOMES	COMPUTER		7,740					
MANAGEMENT CO.	SERVICES							
MARTYNOWSKI	COMPUTER		450					
CONSULTING	SERVICES						Seminar Expense	
MICHAEL ARENDS	COMPUTER		90					
	SERVICES							
MIKE GRAY	COMPUTER		1,080					
	SERVICES						Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 12,820				TOTAL	

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LSN - \$2952.00
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 37,227 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 32,940
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 4,294
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? NONE
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ NONE
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.